are available. In fact, I believe that suturing these wounds is usually undesirable and simply stitches the bugs in, unless they are properly excised—which, especially on the face, probably should seldom be done. Surgical excision and débridement is obviously necessary for some of the wounds we see, especially if foreign material has been forced in; but to say that surgery is essential for all wounds no matter how trivial is, I believe, untrue. Moreover, simply washing can scarcely be described as surgery.

The recommendation also states that if the last booster dose was given more than 12 months ago a single dose of toxoid should be given if surgical treatment is judged to be inadequate. This would be largely guesswork and, as is stated earlier in the article, reinforcing doses should be given every five to 10 years—and these would render boosters unnecessary. It would also rapidly increase the number of "overimmunised" patients. Many children attend the department regularly with minor injuries and they certainly do not need a booster every year.

Sometimes patients develop tetanus following injuries so trivial that they cannot remember them, so in theory at least anyone with even a bruise should be given a booster and I tend to err in this direction myself.

I agree that the principles of tetanus surveillance and prophylaxis need to be restated but I do not think that the guidance given in this article is satisfactory. I believe that the regimen proposed by Dr J O'Brien at Hereford General Hospital, and published in *A and E News*, the journal of the Casualty Surgeons Association in April is superior. It was recommended at the last International Conference on Tetanus (1978) and is as follows: (1) Giving the patient with one previous injection of toxoid more than one month before the injury a second injection and requesting him to come for a third injection in six to 12 months. (2) Giving a patient with two previous injections a third injection if six months have passed since the last injection. (3) Giving the patient with three previous injections a fourth injection if five years have passed since the last injection. (4) Giving the patient with four or more previous injections a booster dose if 10 years have passed since the last injection. (5) All patients not previously immunised should also have an injection of globulin at a different site from the toxoid injection.

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Side effects of benoxaprofen

SIR,—Concern has been expressed over the safety of benoxaprofen. This letter reports experience with the drug in 204 patients, many of whom have taken the drug for over a year. One hundred and sixty-one of the cases suffered from inflammatory polyarthritis of the rheumatoid type. A further 15 had psoriatic arthritis, nine ankylosing spondylitis, and six osteoarthritis. The remaining 13 had spondylosis or capsulitis. One hundred and three were treated with benoxaprofen alone and 101 with benoxaprofen plus other drugs.

Patients were reviewed frequently as outpatients and graded for clinical response (according to their own preference) as good, moderate, or poor. They were also interrogated for side effects and investigated appropriately if side effects occurred. Fifty-seven patients graded the effects of the drug as good, 84 as moderately good, and 63 as poor. Sixty-two of the 63 patients with a poor response stopped taking the drug. Forty-one of the 84 with a moderate response stopped, and 23 of the 57 with a good response stopped. Thus in over one-third of the patients the drug provided a useful response and the patients were able to continue taking the drug for long periods.

Among the 204 patients 38 complained of gastrointestinal discomfort. There was only one case of frank bleeding. Six persisted with the drug despite the symptom. Thirteen had rashes, and all gave up taking the drug. In addition 36 developed a phototoxic skin reaction. Ten persisted with the drug despite the discomfort. No phototoxic reaction occurred during the winter months apart from two patients who went abroad to sunbathe. The symptom disappeared rapidly in all patients who stopped the drug. Seven developed onycholysis. None of the side effects were irreversible apart from the single patient with gastrointestinal haemorrhage, who recovered. In no case was there any evidence of liver damage.

The drug combined well with other treatments used in arthritis. There was statistical evidence that combination with other drugs was not attended with a higher incidence of side effects. It was attended with some improvement in the effectiveness of the drug, especially in moving the patients out of the poor-responders group and into the moderate-responders group.

The fact that no case of overt liver damage occurred in this series of 204 cases, or in Dr N Cardoe and Dr J P Halsey's series (8 May, p 1365) of 300 cases, puts the occurrence of five deaths from liver damage in a series of six cases in a single hospital (8 May, p 1372) into a curious light and must raise serious doubts about the connection between the drug and these five fatalities. Indeed, in Dr Cardoe and Dr Halsey's cases serial estimations of the alkaline phosphatase tended to fall, not rise.

Much more information is required about the possibility of intercurrent hepatitis, variations in local clinical and environmental factors, and concurrently administered drugs before this extraordinary variation in outcome, resulting in five deaths, is laid at the door of a drug which has failed to behave in this way in a large series of patients elsewhere in the UK.

Benoxaprofen certainly produces a number of side effects which are clearly recognisable as being due to the drug, and the percentage occurrence is certainly as great as with other drugs in the same broad grouping. None of these clearly connected side effects has so far proved fatal or irreversible. Caution in giving drugs, particularly anti-inflammatories, to people over the age of 80, is a universal requirement of medical practice, and it would be to the detriment of elderly patients if it were thought that other drugs required less caution than benoxaprofen. Treatment at any age with any drug must always be a balance of good and bad effects, and the ability of any new drug to do harm must always be a matter of serious concern.

By the same token, the fact that the harm is due to the drug must be established beyond reasonable doubt if we are to offer patients treatment on the basis of evidence rather than prejudice. Our duty not to deprive our patients of useful treatment because of ill-founded fears is as great as our duty not to force on them useless treatments due to enthusiastic commercial pressures unless we, and our patients, prefer to tolerate the disease state unmodified by drug treatment rather than take any risk.

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SIR,—The reports of complications occurring during benoxaprofen therapy have now led to lay press comment. In today's *Guardian* attention was drawn to the hepatic and renal complications (with several fatalities).

In a recent report of a case of renal failure following benoxaprofen therapy[1] we described complete anuria associated with multisystem disease and LE cells in the peripheral circulation. This patient's life was saved by the immediate introduction of massive steroid therapy. It is essential, therefore, that in addition to drawing attention to renal and hepatic complications the importance of immediate introduction of massive steroid therapy should be emphasised.

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[1] Fine W, Tallis RC, Osman KM. *Postgrad Med J* 1982;58:317-8.

SIR,—I have followed with interest the controversy which has surrounded the recent publication of articles relating to benoxaprofen and its efficacy and toxicity. Most of the letters (29 May, p 1630, and 12 June, p 1782) which I have seen published following the original articles by Drs J P Halsey and N Cardoe (8 May, p 1365), Dr Colin Hindson and others (p 1368), and Drs Hugh McA Taggart and Joan M Alderdice (p 1372), have been from hospital practitioners. Since the drug was released for use in general practice in October 1980, I have been monitoring the patients who have received benoxaprofen and to date have 96 patients who have received the drug for periods varying from one month to 10 months.

I would concur with the original paper by Dr Halsey and Dr Cardoe that the major side effect of benoxaprofen is photosensitivity, which shows an overall incidence in my series of 26%. If the patients who are taking the drug during the summer months (April to September inclusive) are isolated, the incidence of photosensitivity rises to almost 50%.

The second commonest side effect has been onycholysis, which I have noted in two patients, neither of whom had noticed the nail changes themselves spontaneously. Milia have been observed in one 82-year-old woman who was so pleased with the beneficial effect of benoxaprofen that despite repeated exhortations she insists on continuing the treatment, maintaining that at her age it matters not that her face is disfigured with spots, she would rather be free of the pain.

Benoxaprofen over a period of some 20 months in general practice has proved to be of great benefit to a number of patients. Its efficacy is demonstrated by the fact that 82% of all the patients so far monitored have found benoxaprofen to be effective both in reducing the pain and in reducing the stiffness associated with their arthritic process.

I have little experience of patients over the age of 65, since 80% of my 96 patients are between the ages of 35 and 65. This has been a deliberate policy on my part. There has been a suggestion that benoxaprofen may show some evidence of improving the arthritic process, and the younger age group has been specifically